

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-032425

STATE FILE NUMBER

FILED OCT 6 1958

Registration District No. 132 Primary Registration District No. 3021 Registrar's No. 154

Health
& Welfare
Public
Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

| | | | | | | | | |
|--|--|---|--|---|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Grundy | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY Grundy | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Trenton | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | c. CITY OR TOWN Trenton | | c 4020 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Cullers Hosp. | | | Length of stay in 1b 11 Hours | | | d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) James S. Garnand | | | | 4. DATE OF DEATH Month Oct. Day 1 Year 58 | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 1-5-23 | | |
| 9. AGE (In years last birthday) 67 | | IF UNDER 1 YEAR Months _____ Days _____ | | IF UNDER 24 HRS. Hours _____ Min. _____ | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | | 10b. KIND OF BUSINESS OR INDUSTRY Farming | | 11. BIRTHPLACE (City and state or country) Grundy Cnty Mo. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William O. Garnand | | | | 14. MOTHER'S MAIDEN NAME Dora Sires | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Mrs. Ruth Garnand Trenton, Mo. | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage About 15 hours Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Arterio-sclerosis DUE TO (c) 331X | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2 | |
| 20a. ACCIDENT <input type="checkbox"/> | | SUICIDE <input type="checkbox"/> | | HOMICIDE <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ | | | | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION | | COUNTY STATE | | |
| 21. I attended the deceased from Sept. 30-1950 to Oct. 1-1958 and last saw ^{him} alive on Sept 30-1958 Death occurred at 3:20 A m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE (Degree or title) B. H. Cullers M.D. | | | | 22b. ADDRESS Trenton, Mo. | | 22c. DATE SIGNED 10-3-58 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 10-3-58 | 23c. NAME OF CEMETERY OR CREMATORY I.O.O.F. Cemetery | | 23d. LOCATION (City, town, or county) (State) Trenton, Mo. | | | |
| 24. FUNERAL DIRECTOR Wm. Gipson | | | ADDRESS Trenton, Missouri | | 25. DATE RECD. BY LOCAL REG. 10-3-58 | | 26. REGISTRAR'S SIGNATURE J. E. Saw | |

(Licensed Embolmer's Statement on Reverse Side)

8991-9 11 110

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed: *Richard D. Collins*

Licensed Embalmer No. *495*

P. O. Address *Fresno, CA*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.